IDAHO MEDICAID
STANDARD STATE PLAN

SECTION1. GENERAL OVERVIEW

1. A. ADMINISTRATIVE AUTHORITIES

The Idaho Department of Health and Welfare is the single State agency designated to administer or supervise the administration of the Medicaid program under Titles XIX and XXI of the Social Security Act. (All references to "the Department" mean the Idaho Department of Health and Welfare.)

The health benefits coverage available under the Standard State Plan provides appropriate coverage for the applicable populations as determined by the Secretary of the US Department of Health and Human Services pursuant to his authority under Title XIX of the Social Security Act. All references to "the Secretary" mean the Secretary of the US Department of Health and Human Services; all references to "the Act" mean the Social Security Act.)

1. B. GEOGRAPHIC CLASSIFICATION

The Standard State Plan is in effect for all geographic and political subdivisions of the State.

1. C. SERVICE DELIVERY SYSTEM

Each individual enrolled in the Standard State Plan is required to enroll in a Primary Care Case Management program, known as "Healthy Connections" under the authority of section 1932(a)(1)(A) of Social Security Act except in areas of the State where a choice of primary care providers enrolled in the program does not exist.

The payment method to the PCCM will be fee for service and a PMPM case management fee.

Mandatory Enrollment Exemptions.
The following eligibility groups are exempt from mandatory enrollment in the PCCM if they chose the Standard State Plan:

- Participants who are also eligible for Medicare
- Children under the age of 19 who are eligible for SSI
- Children under the age of 19 who are eligible under 1902(e)(3) of the Social Security Act
- Children under the age of 19 who are in foster care or other out of home placement
- Children under the age of 19 who are receiving foster care or adoption assistance under title IV-E

SECTION 2. COVERED POPULATIONS

2. A. COVERED INDIVIDUALS

The Idaho Medicaid Standard State Plan is available to the groups specified in this Section.

- AFDC Related Individuals
- Pregnant Women and infants under 1 year of age with family incomes up to 133% of the FPL
- Pregnant Women determined provider qualifies under presumptive eligibility criteria

- Low Income Children who meet Title XIX income guidelines
- Children up to 185% of the FPL under Title XXI

2. B. GENERAL CONDITIONS OF ELIGIBLITY

Each individual provided Medical Assistance under this State plan must meet the conditions of eligibility described 42 CFR Part 435 and Section 2 and applicable attachments to the Idaho State Plan.

Each individual provided Medical Assistance under this State Plan must meet the applicable non-financial eligibility conditions.

2. C. **APPLICATION PROCEDURES**

The Department meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medical Assistance.

The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that includes informing each eligible individual of available benefit options.

The Department will provide such information, in writing, to covered populations, at the following opportunities:

- Initial application for assistance;
- Notice of eligibility determination; and
- Selection of primary care case manager.

To ensure that children are provided with the benefit package that will lead most directly to desired health outcomes, and to ensure that these benefits represent the most effective and efficient use of scarce health resources, Idaho Medicaid will incorporate a health risk assessment into Idaho's eligibility determination process and primary care case management (PCCM) program, Healthy Connections.
Applicants for medical assistance will complete an accompanying health questionnaire designed to assess general health status and health behaviors. The questionnaire will also serve as a screening tool to determine whether the applicant has special health needs. The Department will also assess whether the applicant requires special education services or is enrolled in Idaho's Children's Special Health Program, Infant and Toddler Program, Children's Mental Health Program or Adult Mental Health Program.

SECTION 3. COVERED SERVICES

3. A. GENERAL PROVISIONS

The Idaho Medicaid Standard State Plan is limited to services listed in section 1905(a)(1) through (5) and (21) of the Act, except for Nursing Facility in section 1905(a)(4)(A), is provided as defined in 42 CFR Part 440, Subpart A. See Section 3.L for special provisions under EPSDT.

3. B. **HOSPITAL SERVICES**

3. B.1 Inpatient Services

The Standard State Plan includes **Inpatient Hospital Services** permitted under sections 1905(a)(1) and 2110(a)(1) of the Social Security Act. These services include semi-private room, intensive and coronary care units, general nursing, drugs, oxygen, blood transfusions, laboratory, imaging service, physical, speech, occupational, heat and inhalation therapy; operating, recovery, birthing, and delivery rooms, routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered.

No limitation is placed on the number of inpatient hospital days. However, such inpatient services must be Medically necessary as determined by the Department or its authorized agent.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Inpatient hospital services do not include those services provided in an institution for mental diseases.

Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

Limitations. The following service limitations apply to the Standard State Plan.

Payment is limited to semi-private room accommodations unless private accommodations are medically necessary and ordered by the physician.

Excluded Services. The following services are excluded from the Standard State Plan.

Elective medical and surgical treatments, except family planning services and medically necessary cosmetic surgery, are excluded from Medicaid payment unless prior approved by the Department or its authorized agent.

New procedures of unproven value and established procedures of questionable current usefulness that are excluded by the Medicare program and other commercial carriers. Questionable procedures are reviewed using the criteria listed in IDAPA 16.03.09.43.

Acupuncture, bio-feedback therapy, and laetrile therapy.

Procedures, counseling, and testing for the inducement of fertility.

Surgical procedures for the treatment of morbid obesity and panniculectomies are excluded unless prior approved by the Department or its authorized agent.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21).

Treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded

from Medicaid, unless determined to be medically necessary by the Department or its designee.

All transplants

3. B.2 **Outpatient Services**

The Standard State Plan includes **Outpatient Hospital Services** permitted under sections 1905(a)(2) and 2110(a)(2) of the Social Security Act. These services include all benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including, but not limited to, observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, injury or illness are covered.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Limitations. The following outpatient services are not covered under the Standard State Plan.

- Physical Therapy
- Psychotherapy
- Occupational Therapy
- Speech Therapy

3. B.3 **Emergency Services**

The Standard State Plan includes **Emergency Hospital Services** provided when necessary to prevent death or serious impairment of health and when conditions dictate use of the most accessible hospital available, even if the hospital does not currently meet the conditions for participation under Medicare or the definitions of inpatient or outpatient hospital services included elsewhere in this State plan. All obstetrical deliveries provided to aliens per Section 1903 (v) (3) of the Act are designated as emergency services.

Limitations. The following service limitations apply to the Standard State Plan.

Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status will be excluded from the above limitation.

The limit of six (6) emergency room visits will be waived for EPSDT recipients.

3. C. AMBULATORY SURICAL CENTER SERVICES

The Standard State Plan includes **Ambulatory Surgical Center Services** in addition to services covered as Inpatient and Outpatient Hospital and Physician benefits permitted under sections 1905(a)(9), and 2110(a)(4) of the Social Security Act, including services provided under section 1905(a)(9).

Ambulatory surgical center services are outlined in applicable

Department rules and must be provided in a facility certified by Medicare as an ASC, and are restricted to those procedures identified by the Medicare program in accordance with 42 CFR 416.65, or identified by the Department as meeting such requirements.

3. D. PHYSICIAN SERVICES

3. D.1 Medical Services

The Standard State Plan includes **Physician Services** permitted under sections 1905(a)(5) and 2110(a)(4) of the Social Security Act. These services include office, clinic, out patient surgery center and hospital treatment by a physician for a medical condition, injury or illness. Physician services are covered whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

The Standard State Plan includes treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in applicable Department rules. Medically appropriate second opinions are covered.

Excluded Services:

Elective medical and surgical treatments, except family planning services without prior approval from the Department

New procedures of unproven value and established procedures of questionable current usefulness that are excluded from Medicare program and other commercial carriers. Questionable procedures are reviewed using the criteria listed in IDAPA 16.03.09.443.

Non-medically necessary cosmetic surgery

Surgical procedures for the treatment of morbid obesity and panniculectomies unless medically necessary for co-morbid conditions.

Acupuncture services, naturopathic services, biofeedback therapy, laetrile therapy, and eye exercise therapy.

Procedures, counseling, office exams and testing for the inducement of fertility.

All transplants

Drugs

Treatment of complications, consequences, or repair of medical procedure in which the original procedure was excluded from Medicaid, unless determined to be medically necessary by the Department or its designee.

Hysterectomies that are not medically necessary and sterilization procedures for participants under age twenty-one (21).

Limitations:

Abortion Services. A legal abortion is only covered to save the life of the mother or in cases of rape or incest as determined by the courts.

When a pregnancy is life threatening and abortion is provided to save the life of the mother, one licensed physician or osteopath must certify in writing that the woman may die if the fetus is carried to term.

Cases of rape or incest must be determined by a court or documented by a report to law enforcement, except that if the rape or incest was not reported to law enforcement, a licensed physician or osteopath must certify in writing that, in his/her professional opinion, the woman was unable to report the rape or incest to law enforcement for reasons related to her health.

Payment for tonometry is limited to two (2) exams for individuals over the age of forty (40) during any twelve (12) month period (either separately or as a part of a vision exam). Individuals with Glaucoma are excluded from this limitation.

3. D.2 Medical and Surgical Services Furnished by a Dentist

The Department will reimburse for treatment of medical and surgical dental conditions by a licensed dentist subject to the limitations of practice imposed by state law, and according to the restrictions and exclusions of coverage contained in IDAPA 16.03.09.800 and 16.03.10.80-85.

Dentist Limitations:

Elective medical and surgical dental services are excluded from Medicaid payment unless prior approved by the Department.

All hospitalizations for dental care must be prior authorized by the Department.

Non medically necessary cosmetic services are excluded.

Drugs supplied to patients for self administration other than those allowed under IDAPA 16.03.09.611 - 666 are excluded.

3. E. **OTHER PRACTITIONER SERVICES**

The Standard State Plan includes the following **Other Practitioner Services** specified in sections 1905(a) (6) and 2110(a)(24) of the Social Security Act. These services include medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Certified Pediatric or Family Nurse Practitioners' Services. Certified pediatric or family nurse practitioners' services are those services provided by certified pediatric or family nurse practitioners as defined by state and federal law**.** This coverage has the same exclusions as Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners as required by Section 1905(a) (21) of the Act. Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code.

Physician Assistant Services. Physician assistant services include those services provided by a physician assistant as defined by state and federal law. This coverage has the same exclusions as Physician Services.

Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code.

Nurse-Midwife Services. Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Certified nurse-midwife services are those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as Physician Services.

3. F. SCREENING SERVICES

3. F.1 **Well Child Screens.**

The Standard State Plan includes periodic medical screens completed at intervals recommended by the AAP, Committee in Practice and Ambulatory Medicine. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services".

3. F.2 Screening Services

Mammography Services. The Standard State Plan covers screening mammographies performed with certified mammography equipment and staff. Screening mammographies will be limited to one (1) per calendar year for women who are forty (40) or more years of age.

3. G. **LABORATORY AND RADIOLOGICAL SERVICES**

The Standard State Plan includes **Laboratory and Radiological Services** permitted under sections 1905(a)(3) and 2110(a)(8) of the Social Security Act. These services include imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition, as well as X-ray, radium or radioactive isotope therapy.

Excluded Services. The following services are excluded from the Standard State Plan.

Laboratory and/or x-ray procedures which are associated with excluded Hospital Services and Physician Services are excluded from payment.

3. H. **FAMILY PLANNING SERVICES**

The Standard State Plan includes **Family Planning Services** permitted under sections 1905(a)(4)(C) and 2110(a)(9) of the Social Security Act. These services include pre-pregnancy family planning services and prescribed supplies are covered including birth control contraceptives.

Family planning services and supplies for individuals of

child-bearing age include counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Standard State Plan covers diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

All requirements of 42 CFR Part 441, Subpart F are met.

Limitations. The following service limitations apply to the Standard State Plan covered under the State plan.

Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply.

Sterilization procedures are limited to persons who are at least twenty-one (21) years of age or older at the time of signing the informed consent form. A person over the age of 21 that is incapable of giving informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must voluntarily sign the informed consent form at least thirty (30) days, but not more than 180 days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.

3. I. HOME HEALTH CARE

The Standard State Plan includes **Home Health Care Services** permitted under sections 1905(a)(7), 1905(a)(8), 2110(a)(14) and 2110(a)(15) of the Social Security Act when prior authorized by the Department.

These services include intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Services also include home health aide services provided by a home health agency.

Home health services are provided in accordance with the requirements of 42 CFR 441.15.

3. J. ESSENTIAL PROVIDERS

3. J.1 **Rural Health Clinic Services**

Rural Health Clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan.

3. J.2 Federally Qualified Health Center Services

Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the State plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Federally qualified health centers are provided within the scope, amount, and duration of the State's Medical Assistance Program as described under applicable Department rules.

3. J.3 **Indian Health Services Facility Services**

Indian Health Service Facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

3. K. MEDICAL TRANSPORTATION SERVICES

The Standard State Plan includes Medical Transportation Services permitted under sections 1905 (as) (26), 1905 (a) (6) and 2110 (a) (17) of the Social Security Act.

The Department will assure the provision of necessary transportation of eligible persons to and from providers of Medicaid services.

Limitations. The following service limitations apply to the Standard State Plan covered under the State plan.

Requests for transportation services will be reviewed and authorized by the Department or its designee. Authorization is required prior to the use of transportation services except when the service is emergent in nature. Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs.

Excluded Services. Transportation to medical facilities for the performance of medical services or procedures which are excluded under the Standard State Plan is excluded.

3. L. SPECIAL SERVICES FOR CHILDREN/EPSDT

EPSDT Services. The Department meets the requirements of sections 1902(a)(43),1905(a)(4)(B), and 1905(r) of the Social Security Act with respect to early and periodic screening, and diagnostic, and treatment (EPSDT) services.

The Standard State Plan includes early and periodic screening, diagnostic and treatment services for individuals up to and including the month of their twenty-first (21st) birthday.

Screening: EPSDT services include the screening, immunization, vision, hearing and dental services recommended by the American Academy of Pediatrics periodicity schedule.

EPSDT services include diagnosis and treatment involving medical care within the scope of Idaho Standard State Plan and such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in the Standard State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services provided under EPSDT.

Limitations:

The Department will not cover services for cosmetic, convenience or comfort reasons.

Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Standard State Plan will

be provided to individuals under the State plan without regard to amount, scope, and duration limitations, but will be subject to prior-authorization.

The additional service must be documented by the attending physician as medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Department or its authorized agent will be required prior to payment.

3. M. **SPECIFIC PREGNANCY-RELATED SERVICES**

The Standard State Plan **Pregnancy-related services**, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

Pregnancy-related and postpartum services are provided for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

The State provides the full range of Medicaid Program services with limitations as elsewhere described in this State plan to eligible pregnant women if such service is related to a medical condition identified by the Department or its authorized agent as pregnancy related (either routine postpartum care, or arising from complications of pregnancy, including delivery).

1902(a)(47) and 1920 of the Act

For presumptively eligible pregnant women, ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under this State plan.

Ambulatory prenatal care for pregnant women is furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

During the presumptive eligibility period, outpatient services related to pregnancy and complications are covered services to pregnant women. Limitations as described elsewhere in this State plan are applicable.

1902(a)(10)(F)(VII) of the Act

Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a) (10) (A) (i) (IV) and 1902(a) (10) (A) (ii) (IX) of the Act.

3. N. LONG-TERM CARE SERVICES

3. T.1 Nursing Facility Services

The Standard State Plan includes **Nursing Facility Services** permitted under section 1905(a)(4)(A) of the Social Security Act. These services include nursing facility services (other than services in an institution for mental diseases) for individuals determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Limitations. The following service limitations apply to Medical Assistance covered under this State plan.

Skilled nursing facility services must have prior authorization before payment is made. For individuals age 21 and older, such prior authorization is initiated by the eligibility examiner who secures consultation from the regional inspection of care to review for a medical decision as to eligibility for nursing facility services and authorization of payment.

Nursing facility care services must have prior authorization before payment is made. For individuals under 21 years of age, such prior authorization is initiated by the eligibility examiner who secures consultation from the periodic medical review team through the nurse consultant for a medical decision as to the eligibility for skilled nursing care services and authorization of payment.

Supplement 1 to Attachment 3.I-A, Program Description

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Supplement I to Attachment 3.I-A, Program Description

1915(i) STATE PLAN HOME AND COMMUNITY-BASED SERVICES

A. Children with Developmental Disabilities

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Respite
Habilitative Supports
Family Education
Community Support Services
Support Broker
Financial Management Services

2. Statewideness. *(Select one):*

[X] The State implements the 1915(i) State plan HCBS benefit statewide, per § 1902(a)(I) of the Act.

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HeBS Benefit. *(Select one):*

0	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one):*		
	X	The Medical Assistance Unit *(name of unit):* Division of Medicaid	
	0	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
0	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.1 0, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

Supplement 1 to Attachment 3.1-A, Program Description

Distribution of State plan DeBS Operational and Administrative Functions.

X *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not perfol'med directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed *(check each that applies):*

Check all agencies and/or entities that perform eachfunction):

	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 State plan HCBS enrollment managed against approved limits, if any	☐	☐	☐	☐
3 Eligibility evaluation	☑	☐	☑	☐
4 Review of participant service plans	☑	☐	☐	☐
5 Prior authorization of State plan HCBS	☑	☐	☐	☐
6 Utilization management	☑	☐	☐	☐
7 Qualified provider enrollment	☑	☐	☐	☐
8 Execution of Medicaid provider agreement	☑	☐	☐	☐
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☐	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each/unction):

Eligibility evaluation: Independent Assessment Provider

Supplement I to Attachment 3.I-A, Program Description

(By checking the following boxes the State assures that):

5. X Conflict of Interest Standards. The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perfonn assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

   N/A

6. X Fair Hearings and Appeals. The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. X No FFP for Room and Board. The State has methodology to prevent claims for Federal financial pa11icipation for room and board in State plan HCBS.

8. X Non-duplication of services. State plan HCSS witt not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Supplement 1 to Attachment 3.1-A, Program Description

1. Pro.iected Number of Unduplicated Individuals To Be Served Annually.
   (Specifyfor year one. Years 2-5 *optional):*

Annual Period	From	To	Projected Number of
Year 1	July 1 2011	June 30 2012	3 195
Year 2	July 1 2012	June 30 2013	3387
Year 3	July 1 2013	June302014	3590
Year 4	July 1 2014	June30 2015	3805
YearS	July 1 2015	June 30 2016	4.033

2. X Annual Reporting. *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

3. Optional Annual Limit on Number Served.

   X The State does not limit the number ofindividuals served during the year.

Supplement I to Attachment 3.I-A, Program Description

1. X Income Limits. *(By checking this box the State assures that):* Individuals receiving State plan HCSS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL

2. Medically Needy. *(Select one):*

X	The State does not provide State plan HCSS to the medically needy.	
0	The State provides State plan HCSS to the medically needy *(select one):*	
	0	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(11l) of the Social Security Act relating to community income and resource rules for the medically needy.
	0	The State does not elect to disregard the requirements at section 1902(a)(IO)(C)(i)(III).

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCSS benefit must be determined through an independent evaluation of each individual. Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCSS benefit are performed *(select one):*

0	Directly by the Medicaid agency
X	Sy Other (*specify State agency or entity with contract with the State Medicaid agency):*
	Contracted Independent Assessment provider(s) will be determined according to state purchasing requirements.

2. Qualifications oflndividuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Qualified Mental Retardation Professional (QMRP) in accordance with 42 CPR 483.430a.

Supplement 1 to Attachment 3.1-A, Program Description

3. Process for Performing EvaluationlReevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this detennination. If the reevaluation process differs from the evaluation process, describe the differences:

Participants applying for 1915(i) state plan option services will be referred to the independent assessment provider (lAP) for initial eligibility determination. The lAP will evaluate the participant using the Scales of Independent Behavior-Revised (SIB-R) and an inventory of individual needs to determine if the participant meets the needs-based criteria. Reevaluations must be completed annually for current participants. The independent assessor must reassess the participant, or establish and document that the existing assessments reflect the participant's current needs.

4. X Needs-based HCBS Eligibility Criteria. *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

- Require assistance due to substantial limitations in three or more of the following major life activities - self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self sufficiency; and
- Reflect the need for a combination and sequence of special, interdisciplinary services due to a delay in developing age appropriate skills occurring before the age of 22.

5. X Target Group(s). Under the waiver of Section 1902(a)(lO)(B) of the Act, the State limits 1915(i) state plan option services to a group or subgroups of individuals:

Benefits' and Section 66-402, Idaho Code.

Supplement 1 to Attachment 3.1-A, Program Description

6. X Needs-based Institutional and Waiver Criteria. *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	JCF/MR (& ICF/MR LOC waivers)	**Applicable Hospital* LOC (& Hospital LOC waivers)**
Require assistance due to substantial limitations in three or more of the following major life activities - self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self sufficiency; and Reflect the need for a combination and sequence of special, interdisciplinary services due to a delay in developing age appropriate skills occurring before the age of 22.	The participant requires nursing facility level of care when a child meets one (1) or more of the following criteria: **01. Supervision Required for Children.** Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. **02. Preventing Deterioration for Children.** Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. **03. Specific Needs for Children.** When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or	**01. Diagnosis.** Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition; and **02. Must Require Certain Level of Care.** Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future; and **03. Functional Limitations.** **a.** Persons Sixteen Years of Age or Older. Persons (sixteen (16) years of age or older) may qualify	The state uses criteria defined in 42 CFR 440.10 for inpatient hospital services.

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	supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. **04. Nursing Facility Level of Care for Children**. Using the above criteria, plus consideration of the developmental milestones, based on the age of the child, the Department's will determine nursing facility level of care.	based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment (Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions) would qualify; or **b.** Persons Under Sixteen Years of Age. Persons (under sixteen (16) years of age) qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or **04. Maladaptive Behavior.** **a.** A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on the Woodcock Johnson Scales of Independent Behavior (SIB-R) or subsequent revision is minus twenty-two (-22) or less; or **b.** Above a Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/ID level of care if they engage in aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment	

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		to control or decrease the behavior; or **05. Combination Functional and Maladaptive Behaviors.** Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in Subsections 585.05 and 585.06 of these rules at a level that is significant and it can been determined they are in need of the level of services provided in an ICF/ID, including active treatment services. Significance would be defined as: (3-19-07) **a.** Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R up to minus seventeen (-17), minus twenty-two (-22) inclusive; or	
		b. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R between minus seventeen (-17), and minus twenty-one (-21) inclusive; or **06. Medical Condition.** Individuals may meet ICF/ID level of care based	

		on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be detennined that they are in need of the -level of services provideet in an ICF/ID, including - active treatment services.	

(By checking thefol/owing boxes the State assures that):

7. X Reevaluation Schedule. Needs-based eligibility reevaluations are conducted at least every twelve months.

8. X Adjustment Authority. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibiJity criteria in accord with 1915(i)(I)(D)(ii).

9. X Residence in home or community. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(Ifapplicable, specify any residential settings, other than an individual's home or apartment. in which residents will befurnished State plan HeBs. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, andfacilitate full access to community services):*

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(By checking the following boxes the State assures that);

1. X There is an independent assessment of individuals determined to be eligible for the State plan HeBS benefit. The assessment is based on:
   - An objective face-to-face assessinent with a person-centered process by an agent that is independent and qualified;
   - COllsultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian,and treating and consulting health and support professionals caring for the individual;
   - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation offunctional ability, and any other records or information needed to develop the plan of care;
   - An examination ofthe individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
   - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
   - A determination of need for (and, ifappHcable, determination thatservice-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. X Based on the independent assessment, the individualized plan of cal'e:
   - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
   - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural SUpp011S;
   - Prevents the provision of unnecessary or inappropriate care;
   - Identifies the State plan HeBS that the individual is assessed to need;
   - Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control;
   - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
   - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances,

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assesSment of individuals with physical and mental needs for nCBS. *(Specify qualifications):*

At a minimum, the qualifications of the individuals conducting the independent assessment include:
1. Qualified Mental Retardation Professional (QMRP) in accordance with 42 CFR 483,430 which includes:
a. Having at least one (I) year experience working directly with persons with mental retardation or other developmental disabilities or;
b. Being licensed asa doctor ofmedicine or osteopathy, or as a nurse Or:
c. HaVing at least a bachelor's degree in one of the following professional categories: psychology, social work, occupational therapy, speech pathology, professional recreation, or other related human services professions.
2. Have training and experience in completing and interpreting assessments.

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4. Responsibility for Plan ofCal'e Development. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of tile individualized, person-centered plan of care. *(Specify qualifications):*

Individuals meeting Qualified Mental Retardation Professional (QMRP) qualifications in accordance with 42 CFR483.430a are qualified to develop the plan of care with direct Department oversight.

5. Supporting the Participant in Plan of Care Development. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Participants who select State plan HCBS are given an orientation to developmental disability services by the Department or its contractor. Participants and their parent/legal guardian may develop their own plan or designate a paid or unpaid plan developer. If the participant and parent/legal guardian chooses to develop their own plan or use an unpaid plan developer, the Department is available to assist in completing all required components. Family-centered planning must include at a minimum the parentllegal guardian, and the plan developer. With the parentllegal guardian's consent, the family-centered planning team may also include additional family members or individuals who are significant to the participant.

Participants and their parentllegal guardian who choose family-direction receive an orientation on family-direction and training from the Department. Families may select a qualified support broker to assist with writing the Support and Spending Plan, or they may choose to become a qualified support broker approved by the Department. As outlined in IDAPA 16.03.13, "Consumer-Directed Services," the participant and parentllegal guardian decides who will participate in the planning sessions in order to ensure the participant's choices are honored and promoted. The family may direct the family-centered planning meetings, or these meetings may be facilitated by a chosen support broker. In addition, the participant and parent/legal guardian selects a circle of support. Members of the circle of support commit to work within the group to help promote and improve the life of the participant in accordance with the participant's choices and preferences, and meet on a regular basis to assist the participant and parentllegal guardian to accomplish their expressed goals.

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6. Informed Choice of Providers. *(Describe how participants are assisted in obtaining In/ormation about and selectingfrom among qualifiedproviders of the* 19J5*(i) services in theplan ofcare):*

Once participants are determined eligible for services, they and their families are given an opportunity to participate in orientation training about developmental disability services in Idaho. During family orientation, participants and their families are provided with a Jist of aU approved providers in the state ofIdaho, which is organized by geographic area. This provider list includes the website link for the children's DD website at ,}vww,redesignforchildren,medicaid.idaho,gov so that participants and families have access to the most current providers in their area and across the state. Both the orientation and the provider list include a statement that the family may choose any willing and available provider in the state, Families are also infortned ofhow to navigate the website to access the list of providers as well as how to access other helpful resources available to them.

Families are also provided with resources on interviewing potential providers and are encouraged to contact multiple providers to identify the provider that can best meet their needs. In addition, families are informed that who they select is their choice and they may change their choice of providers if they want. The plan developer is utilized to assist families in selecting service roviders at the famil 's re uest.

7" Process fOl" Making Plan of Care SubJect to the Approval ofthe Medicaid Agency. *(Describe the process by which the plan ofcare is made subject to the approval ofthe Medicaid agency):*

In both the traditional and family-directed options, the plan is developed by the participant and parent/legal guardian with their support team. The supp011 team is typicalJy comprised of the plan developer or a support broker, the parent/legal guardian, at least one involved care giver and any friends, family or support staff that the family wants to invite. The number of people who can be involved is not limited. Besides the parent/legal guardian, the plan developer is the only person who is required to be a member of the support team.

In the traditional model, the plan developer submits the plan of service to the Department at least 45 days prior to the expiration date ofthecutrent plan of service. This requirement is stated in IDAPA 16,03.10. The Department has 45 days to review the plan of service, discuss any issues with the plan developer, request changes as needed, and enter the authorization into the MMIS.

Participants and their parents or legal guardians who choose to family-direct their services submit their Support and Spending Plan directly to the Department for review and authorization, The Depaltment has ten (10) days to review the plan. The participant and pal'ent/legal guardian, and their circle of supports are in charge of how long the plan development process takes. The process may take from a few days to much longer, depending on the needs and wants ofthe participant, their family and the support team.

The IAP conducts and/or collects a variety of assessments and determines the participant's individualized budget at the time of initial application and on an annual basis, for both the traditional and the family-directed option.

The lAP conducts the following assessments at the time ofthe initial application for children's DD services:

• Scales of Independent Behavior - Revised (Sffi-R) functional assessment.

• Medical, Social and Developmental Assessment Summary.

At the time of annual re-determination, the lAP conducts and/or reviews the following:

• The Medical, Social and Developmental Assessment Summary is reviewed and updated.

• The SlB-R results are reviewed and another assessment performed ifthere are significant changes in the participant's situation or the reassessment criteria are met.

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The following assessments are gathered 011 an as-needed basis or may be used as historical information at the time of both initial and annual re-determinations:

• Psychological evaluations, including evaluations regarding cognitive abilities, mental health issues and issues related to traumatic brain injury.

• Neuropsychological evaluations.

• Physical, occupational and speech-language pathology evaluations.

• Developmental and specific skill assessments.

The results of a physical examination by the participant's primary care physician are provided to the lAP 011 an annual basis. The physician can provide information using the Medical Care Evaluation Form and/or by submitting a narrative report.

The service and support desires and needs of participants measured by the Scales of Independent Behavior Revised (SIB-R), historical record of service expenditures, when available, and the characteristics of persons served measured by the Idaho Individual Budget Screen are used by the lAP in a stepwise regression analysis to develop a prospective individual budget for each participant. This budget-setting is completed by the lAP in advance of the family-centered planning process and is used in the development of a plan of service.

Participants using traditional State plan HCBS, and their support team, must be assessed for health and safety issues. Participants using the family-directed option, and their support team, must complete safety plans related to any identified health and safety risks and submit them to the Department.

In the traditional option, the palticipant and parent/legal guardian's needs, goals, preferences and health status are summarized on the plan of service. This document is a result of the family-centered planning meeting listing a review of all assessed needs and participant and parent/legal guardian preferences. In addition, the plan developer is responsible to collect data status reviews from all paid providers, synthesize all of the information and include it on the plan of service. The participant's parent/legal guardian sign the plan of service to indicate it is correct, complete, and represents the participant and parent/legal guardian's needs and wants.

Family-directed participant's needs, goals, preferences, health status, and safety risks are sumtllarized on the Support and Spending Plan and in the Family-Direction workbook. The circle of supports, using family-centered planning, develops these documents and submits them to the Department at the time of initial/annual plan review.

Participants and their parentJ1egal guardian, along with other members of the support team can receive information regarding State plan HCBS through several methods:

• The Department of Health and Welfare web site for Children's DO Services will have a page giving a detailed explanation for each service provided under the 1915(i) state plan option. This infonnation will be posted on the website following federal and state approval, and is anticipated to be posted no later than the implementation date of July 1,2011. The URL for the web site is: www.redesignforchildren.medicaid.idaho.gov.

• The lAP manual includes a list of all State plan HCBS with a description of what each service entails. The lAP uses this page to explain the various options to initial applicants.

• The lAP provides each new applicant with a Consumer Tool Kit which includes a listing of agencies in the local area that provide developmental disabilities selvices for children.

• The plan developer is charged with verbally explaining the various programs and options to the participant and parent/legal guardian during the family-centered planning process, under the traditional option.

• The suPPOtt broker is charged with assisting the participant and parent/legal guardian to assess what services meet their needs, under the family-direction option.

Idaho requires that a family-centered planning process be utilized in plan development to ensure that participant goals, needs and preferences are reflected on the plan of service or on the Support and Spending Plan.

Plan developers, which can include a paid or unpaid person, are trained in family-centered planning, and possess the education and experience needed to assist families in making decisions about their child's course of treatment and Medicaid services. The child's goals, needs, and resources are identified through a Comprehensive Review process that includes review of assessments and history of services, and family-centered planning.

Participants and their parent/legal guardian who choose to family-direct must attend training offered by the Department prior to submitting a Support and Spending Plan. Completion of this training is documented in the family-direction quality assurance database. The training covers participant and parent/legal guardian responsibilities in family-direction and the process of developing a Support and Spending Plan. The family-directed option utilizes a workbook and a support broker to ensure that the participant's individual goals, needs and preferences are thoroughly explored and prioritized during the plan development process.

Children's State plan HCBS participants typically receive a variety of services and other supports to address their needs and wants. The family-centered planning team works to ensure that the plan of service adequately reflects the necessary services. The plan of service is a single plan that includes the goals, objectives and assessment results from all of a child's services and supports in the child's system of care. The plan of service will demonstrate collaboration is taking place among providers and that objectives are directly related to the goals of the family.

Under the traditional option, the responsibility is placed on the plan developer, plan monitor, IAP, and Department to complete the plan development process.

- The lAP is responsible to submit the assessment and individualized budget to the plan developer.

- The plan developer and monitor is responsible to:

  - Ensure that services are not duplicative, and are complimentary and appropriate

  - Work with the members of the family-centered planning team and providers to ensure that the service needs of the participant are reflected on the plan of service

  - Act as the prim81y contact for the family and providers

  - Link the family to training and education to promote the family's ability to competently choose from existing benefits

  - Complete a comprehensive review of the child's needs, interests, and goals

  - Assist the family to allocate funding from their child's individualized budget

  - Monitor the progress of the plan of service

  - Ensure that changes to the plan of service are completed when needed

  - Facilitate communication between the providers in a child's system of care

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Under the family-directed option, the responsibility is placed on the participant and parent/legal guardian to coordinate services with assistance from the Department and FIEA as required.

- The lAP is responsible to submit the assessment and individualized budget to the Department.
- The family and a suPPOtt broker use the Family-Direction Workbook and the family-centered planning process to identify the participant's needs and develop a Support and Spending Plan.
- The Department reviews the plan to ensure that all health and safety risks are covered.
- The Fiscal/Employer Agent (FIEA) ensures that duplication of payment does not occur.

Each participant using traditional services must select and use a paid or unpaid plan monitor who will monitor the plan. The family-centered planning team must identify the frequency of monitoring but at a minimum it must occur at least annually. In addition, the plan must be monitored for continuing quality. Plan monitoring ensures that the plan of service continues to address the participant's goals, needs and preferences by requiring:

- Contact with the parent/legal guardian at least annually or as needed to identify the current status of the program and changes if needed. Changes may be made to the plan when a service is added or eliminated, when service objectives or goals are changed, when there is a change in provider, or when the child's level of needs change. The plan should be changed to ensure that the services continue to align with the child's individualized budget and that the family is up to date on the services their child is receiving.
- Contact with service providers t() identify barriers to service provision.
- Discuss satisfaction regarding quality and quantity of services with the family.
- Review of provider status reports and complete a plan monitor summary after the six month review and for annual plan development.

Participants and their parent/legal guardian who family-direct their services may choose to assume the responsibility of plan monitoring themselves, utilize members of the circle of supports, or require a support broker to perform these duties. This decision is made in the circle of supports during the family-centered planning process and is reflected in the Family-Direction workbook.

Each participant is required to complete a new plan of service annually. The lAP sends written notification 120 days prior to the expiration of the current plan. The notice requests that the family schedule a meeting with the lAP to begin the process of eligibility re-determination and annual budget detennination. Families will work closely with the plan developer and at any time can detennine the need to add, decrease, or change services. Both plans and addendums will be reviewed by the Department.

Participants and their parent/legal guardian who are family-directing their services are required to complete a new Support and Spending Plan annually. Families can request changes be made to their Support and Spending plan at any time during the plan year by completing a plan change fonn and submittin to the De artment for review.

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8. Maintenance of]»sn of Care Forms. Written copies 01' electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53, Service plans are maintained by the following *(check each that applies):*

X	Medicaid agency	o I Operating agency	10 I Case manager
0	Other *(specify):*		

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1. State plan HeDS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HeBS listed in Attachment 4.19-B that the State plans to cover):*			
Service Title: I Respite			
Service Definition (Scope):			
Respite is provided to the participant on an intermittent or short-telm basis. because of the absence or need for relief of the primary unpaid caregiver. Respite services are provided in a variety of settings and may be provided on an hourly or daily basis. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a developrrientaLdisabilitiesagencY,oi in community settings. Respite may only he Qffered to participants who have an unpaid primary caregiver living in the home who requires relief. Limitations: -Payment for respite services are not made for room and board. -Respite cannot be provided during the same time other HCBS are being provided to apat1icipant. ·Respite cannot be provided On a continuous, long-term basis where it is part of daily services that would enable an unpaid caregiver to work. -Respite services shall not duplicate other Medicaid reimbursed services.			
Additional needs-based criteria for receiving the service, if applicable *(specify):*			
N/A			
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*			
X	Categorically needy *(specify limits):* Subject to individualized budget maximums.		
0	Medically needy *(specify limits):*		
Provider Qualifications *(For each type of provider. Copy rows as needed);*			
Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Developmental Disabilities Agency		Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide respite in a DDA:

		Code.	Providers must meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the participant and parent/legal guardian; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; be willing to accept training and supervision; be free of communicable diseases; and pass a criminal background check.
Respite Care Provider			Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide respite: Providers must meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the participant and parent/legal guardian; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; be willing to accept training and supervision; be free of communicable diseases; and pass a criminal background check.
Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:			

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Provider Type *(Specify):*	Entity Responsible for Verification *Speci :*	Frequency of Verification *(Specify):*
Developmental Disabilities Agencies	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns
Respite Care Provider	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: Habilitative Supports

Service Definition (Scope):

Habilitative Supports provides assistance to a participant with a disability by facilitating their independence and integration into the community. This service provides an opportunity for a participant to explore their interests and improve their skills by participating in natural environments.

Habilitative Supports is not active treatment. Instead, the participant learns through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization and relationship building, and participation in leisure and community activities.

This service is only provided in the participant's home or in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or therapy, nor are they intended to supplant the primary caregiver.

The supports provider must maintain a log of the habilitative support services in the participant's record documenting the provision of activities outlined in the plan of service. Supports that take place in both the home and community must ensure the participant is actively participating in age appropriate activities and is engaging with typical peers.

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Provider Type *(Specify):*	Entity Responsible for Verification *Specify:*	Frequency of Verification *(Specify):*
Developmental Disabilities Agencies	Department of Health and. Welfare	- At initial provider agreement approval or renewal. - At least every three years, and as needed based on service monitoring concerns.
Respite Care Provider	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns

Service Delivery Method. *(Check each that applies):*

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: Habilitative Supports

Service Definition (Scope):

Habilitative Supports provides assistance to a participant with a disability by facilitating their independence and integration into the community. This service provides an opportunity for a participant to explore their interests and improve their skills by participating in natural environments.

Habilitative Supports is not active treatment. Instead, the participant learns through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization and relationship building, and participation in leisure and community activities.

This service is only provided in the participant's home or in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or therapy, nor are they intended to supplant the primary caregiver.

The supports provider must maintain a log of the habilitative support services in the participant's record documenting the provision of activities outlined in the plan of service. Supports that take place in both the home and community must ensure the participant is actively participating in age appropriate activities and is engaging with typical peers.

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Limitations:

- Habilitative Supports must be necessary to ensure the participant's safety if he or she cannot be left unsupervised due to health and safety concerns or cannot be cared for in the community in a normalized child care center due to the severity of their diagnosis.

- Habilitative Supports cannot be provided during the same time other HCBS are being provided to a participant.

- Habilitative Supports shall not duplicate other Medicaid reimbursed services which include but are not limited to: Respite, Psychosocial Rehabilitation and Partial Care.

Additional needs-based criteria for receiving the service, if applicable *(speeify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☐X	Categorically needy *(specify limits):*
	Subject to individualized budget maximums
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Developmental Disabilities Agency		Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.	Individuals m training requi "Developmen in addition mu qualifications in a DDA: Must be at lea high school gr demonstrate th according to a communicatio the ability to d cooperatively willing to acce free of commu knowledge of agree to practi situations that criminal back competency c Department re requirements.

Verification of Provider Qualifications (*For each provider type listed above. Co rows as needed:*

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Provider Type *(Spec(fy):*	Entity Responsible for Verification *S eci :*	Frequency of Verification *(Specify):*
Developmental Disabilities Agencies	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns

Service Delivery Method. *(Check each that applies):*

☐ Participant-directed ☒ Provider mana ed

Service Specifications *(Specify a service title for the HeBS listed in Attachment 4.19-B that the State lans to cover, :*

Service Title:	Family Education
Service Definition (Scope):	
Family education is professional assistance to families to help them better meet the needs of the participant. It offers education to the parent/legal guardian that are specific to the	

Additional needs-based criteria for receivin the service, if a licable *s eci :*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

X	Categorically needy *(specify limits):*
	Subject to individualized budget maximums.
☐	Medically needy *(specify limits):*

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Provider Qualifications *(For each type of provider. Copy rows as needed:*

Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Developmental Disabilities. Agency.		Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.	Individuals must meet the minimum general training requirements. defined in IDAPA rule "Developmental Qisabilities Agencies", and in addition must meet the following qualifications to provide family education in a DDA: Must hold at least a bachelor's degree in a health, human services, educational, behavioral science or counseling field from a nationally accredited university or college; must have one year experience providing care to children with developmental disabilities; must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; and must complete a supervised practicum.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed:*

Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Developmental Disabilities Agencies	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Community Support Services
Service Definition (Scope):	

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Community Support Services provide goods and supports that are medically necessary and/or minimize the participant's need for institutionalization and address the participant's preferences for:

- Personal support to help the participant maintaill health, safety, and basic quality of life.
- Relationship support to help the participant establish and maintain positive relationships with itmne4iate. family members, friends, or others in order to build a natural support

Additional needs-based criteria for receiving the service, if applicable *(specify)*:	
N/A	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:	
X	Categorically needy *(specify limits)*:
	Subject to the individualized budget amount.
☐	Medically needy *(specify limits)*:

Supplement 1 to Attachment 3.l-A, Program Description

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Community Support Agency	If required to identify goods or supports. For example, a Community Support providing speech-language pathology must have a current speech-language pathology licensure.	If required to identify goods or supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.
Community Support Provider	If required for identified goods or supports. For example, a Community Support providing speech-language pathology must have current speech-language pathology license.	If required for identified goods and supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

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Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*		
Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Commullity Support Agency	Participant and parent/legal guardian Paid Support Broker (if applicable) Department of Health and Welfare (during retrospective quality assurance reviews)	Initially and annually, with review of e||1ploYIl1ent/vendor agreement
Community Support Provider	Participant and parent/legal guardian Paid Support Broker (if applicable) Department of Health and Welfare (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	☐	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: Financial Management Services

Service Definition (Scope):

The Department will offer financial management services through any qualified fiscal employer agent (FEA) provider through a provider agreement.

FEA providers will complete financial consultation and services for a participant who has chosen to family-direct their services in order to assure that the financial information and budgeting information is accurate and available to them as is necessary in order for successful family-direction to occur.

A. Payroll and Accounting. Providing payroll and accounting supports to participants that have chosen the family-directed community supports option;

B. Financial Reporting. Performing financial reporting for employees of each participant;

C. Financial Information Packet. Preparing and distributing a packet of information, including department approved forms for agreements, for the participant and family hiring their own staff;

D. Time Sheets and Invoices. Processing and paying timesheets for community support workers and support brokers, as authorized by the participant and parent/legal guardian according to the participant's Department authorized support and spending plan;

E. Taxes. Managing and processing payment of required state and federal employment taxes for the participant's community support worker and support broker;

F. Payments for goods and services. Processing and paying invoices for goods and services, as authorized by the participant and parent/legal guardian according to the participant's support and spending plan;

G. Spending information. Providing each participant and parentllegal guardian with reporting information and data that will assist the pmticipant and parent/legal guardian with managing the individualbudget;i

H.Quality assurance and improvelTIent,Participation in departInentquality assurance activities.

A

Additional needs-based criteria for receiving the service, if applicable *(specify):*
N/A
Specify limits (if any) on the amount, duration, or seope of this service for *(chose each that applies):*
X Categorically needy *(specify limits):*
Only participants who select the The FEA must not either provide

information to the participant and parent/legal guardian about other goods and services.

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Fiscal Employer/Agent			Agencies that provide financial management services as a FEA must be qualified to provide such services as indicated in section 3504 of the Internal Revenue Code.

Verification of Provider Qualifications (*For each provider type listed above. Co rows as needed* :

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Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Fiscal Employer/Agent,	Department of Health and Welfare	At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and thereafter at least every three years by Department review.
Fiscal Employer/Agent	Department of Health and Welfare	At the time of application, as indicated by a r be co Depa provi at lea by Department review.

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	☐	Provider managed

Service Title: Support Broker

Service Definition (Scope):

okers provide counseling and assistance for participants and their parent/legal ith arranging, directing, and managing services. They serve as the agent or ive of the participant to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. This includes providing pa for gathering and revi them by the FEA. Pra Examples of skills tra with directing service workers, managing w problem-solving. The parent/legal guardian

unity support ication and cipant and

Support broker servic vided as a l guardian's

- Develop a written support and spending plan with the participant and family that includes the supports the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three backup plans *should* a support fallout.

- Assist the participant and family to monitor and review their budget through data and

egal guardian's satisfaction

requested.

In addition to the required minimum support broker duties, the support broker must be able to provide the following services when requested by the participant and parent/legal guardian:

- Assist the participant and parent/legal guardian to develop and maintain a circle of support.
- Help the participant and family learn and implement the skills needed to recruit, hire, and monitor community supports.
- Assist the participant and parent/legal guardian to negotiate rates for paid Community Support Workers.
- Maintain documentation of supports provided by each Community Support Worker and participant and parent/legal guardian's satisfaction with these supports.
- Assist the participant and parent/legal guardian to monitor community supports.
- Assist the participant and parent/legal to resolve employment-related problems.
- Assist the participant and parent/legal to identify and develop community resources to meet specific needs.

Support Brokers provide counseling and assistance for families by arranging, directing and managing services. This includes providing families with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the FEA. Support Broker qualifications, requirements and responsibilities as well as allowable activities are described in Idaho Administrative Rules.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(choose each that applies):*

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X	Categorically needy *(specify limits):* Only participants who select the Family-Directed Option may access this service. Support brokers may not act as a fiscal employer agent, instead support brokers work together with the participant and parent/legal guardian to review participant financial information that is produced and maintained by the fiscal employer agent.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Support Broker			Specific requirements outlined in Idaho Administrative Code - IDAPA 16.03.13 include review of education, experience, successful completion of Support Broker training and ongoing education. The parent/legal guardian can be an unpaid support broker for the participant and are subject to the same qualification requirements as paid support brokers.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed:*

Provider Type *(Specify):*	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Support Broker	Department of Health and Welfare	At the time of application, and review of ongoing education requirements and by participant/parent/legal guardian when entering into employment ag

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	☐	Provider managed

Supplement I to Attachment 3.I-A, Program Description

2. X Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians: There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCSS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCSS. *(Specify (a) who may be paid to provide State plan HeBS; (b) how the State ensures that the provision of services by such persons* is *in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Respite is the only State plan HCBS that may be provided by relatives of a participant. A parent/legal guardian cannot furnish State plan HCBS, but other relatives may be paid to provide respite services whenever the relative is qualified to provide respite as defined in this application. There are numerous safeguards in place to ensure that payments are only made for services rendered including oversight by provider agencies, family-centered planning teams, circles of supports, fiscal/employer agent, and by the Department through review and approval of plan of services and retrospective quality assurance reviews.

All providers are precluded from being in a position to both influence a participant and parent/legal guardian's decision making and benefit financially from these decisions. Payments for family-directed services rendered are made only after review and approval by the participant and parent/legal guardian and review by the Fiscal Employer Agent. Additionally, the participant's Support Broker and Circle of Supports are available to address any conflicts of interest.

Individual Budget Amount: There is a limit on the maximum dollar amount of HCBS State Plan services authorized for each specific participant.

(a) All HCBS services are included in the budget.

(b) The service and support desires and needs of participants measured by the Scales of Independent Behavior Revised (SIB-R), historical record of service expenditures, when available, and the characteristics of persons served measured by the Idaho Individual Budget Screen are used in a stepwise regression analysis to develop a prospective individual budget for each waiver participant. The budget-setting methodology will correlate a participant's characteristics with the participant's individual budget amount, so participants with higher needs will be assigned a higher individual budget amount. Maximum dollar amounts will be based on individual assessed needs. This budget-setting is completed by the Independent Assessment Providers (lAP) in advance of the family-centered planning process and is used in the development of an Action Plan.

(c) The individual budget is based on the perspective that funding should be tied principally to individual need. The model seeks out the factors that contribute the most to explaining observed variance in costs and discards those that do not appear to influence cost. A review

will be done on an annual basis to evaluate the current variables to determine if they continue to contribute to the cost of individuals. In the end, the model identifies the mix and weight of variables that best fits the array of observed costs across the individuals receiving services. Ongoing monitoring of the statistical model, complaints, appeals, and paIticipant outcomes will be conducted by the Department to ensure that assigned budgets are sufficient to assure health and safety ofpaIticipants in the community. When the Department determines that a change needs to be made to the individual budget methodology, participants will be sent notification of the change prior to implementation.

(d) Participants who believe that their assigned budget does not accurately reflect their needs may appeal the decision and request a fair hearing.

(e) The Department has processes in place for participants to be re-evaluated and have a new budget assigned when the participant has a change in condition that requires additional services or higher cost services. Participants may request a re-evaluation by submitting documentation of changes to individualized needs to the TCM. If the docwnentation supports the need for additional budget funds, the TCM forwards the request to the lAP for a new individual budget evaluation. If the documentation does not support the need for additional budget funds, the TCM provides written notification to the participant of the decision and the right to appeal.

(f) Participants are notified of their eligibility for HCBS services and given an annual individual budget at the time of their initial determination or annual re-determination. Each participant receives written notification of the set budget amount. The notification includes how the participant may appeal the set budget amount decision. Individual budgets are re-evaluated annually by the lAP and written notification of the set budget amount are sent annually.

A summary of the individual budget methodology is included in IDAPA rules. Any time a change is made the rules are published and open for public comment. In addition, whenever changes are made to the methodology Idaho will notify all families and providers of the change prior to implementation.

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Definition: Participtmt-direction means self-direction of services per §1915(i)(l){G)(iii).

1. Election of Participant-Direction. *(Select one):*

0	The State does not offer opportunity for pa11icipant-direction of State plan HCBS.
X	Every participant in State plan HCBS (or the participant's representative) is afforded the dpportunity to elect to direct services. Altemate service delivery methods are available for participants who decide not to direct their services.
0	Pa11icipants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HeBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide,' and, (d) other relevant information about the approach to participant-direction):*

[daho's family-direction option provides a more flexible system, enabling participants and their parent/legal guardian to exercise more choice and control over the services they receive which helps them live more productive and participatory lives within their home communities. This option is provided within the existing system so that it is sustainable and reflects the value of this option for all participants and their parents/legal guardians who choose to direct their own services and supports. The process supports participant and parent/legal guardian preferences and honors their desire to family-direct their own services; how and when supports and services are provided; and who will assist them in developing and lnonitoring a realistic support and spending plan that accurately reflects their individual wants andneeds.

Once participants are determined eligible for State plan HCBS, anindividualized budget is developed for each participant. The budget model provides participants with an individual budget and a maximum level of funding that varies according to individual needs, and allows for spending flexibility within the set budgeted dollars. The support need is determined from an evaluation completed using a uniform assessment tool. Upon completion of the assessment, the individualized budget is reviewed with the participant and parent/legal guardian by the Department or its Contractor.

Participants then have the option to choose Family-Directed Services (FOS). The FDS option allows eligible participants and their parentllegal guardian to choose the type and frequency of supports they want, to negotiate the rate of payment, and to hire the person or agency they prefer to pl'ovide those supports. Participants and the parent/legal guardian must use a support broker to assist them with the family-directed process. This can be accomplished in one of

two ways: The family may choose to hire an approved support broker to perform specific duties as needed, or the parenVlegal guardian may choose to act as an unpaid support broker with the ability to perform the full range of support broker duties. If a parent/legal guardian wishes to act as an unpaid support broker for the participant, they must complete the support broker training and be approved by the Department. Paid support broker services are included as part of the community supp0l1 services that participants and their parent/legal guardian may purchase out of their allotted budget dollars.

Support broker duties include planning, accessing, negotiating, and monitoring the family's chosen services to their satisfaction. They can assist families to make informed choices, participate in a family-centered planning process, and become skilled at managing their own supports. The support broker possesses skills and knowledge that go beyond typical service coordination. The support broker assists participants and parents/legal guardians to convene a circle of supports team and engages in a family-centered planning process. The circle of supports team assists participants and parents/legal guardians in planning for and accessing needed services and supports based on their wants and needs within their established budget.

The FDS option gives participants and their parent/legal guardian the freedom to make choices and plan their own lives, authority to control the resources allocated to them to acquire needed supports, the opportunity to choose their own supports and the responsibility to make choices and take responsibility for those choices. Families and support brokers are responsible for the following:

- Accepting and honoring the guiding principles of family-direction to the best of their ability.
- Directing the family-centered planning process in order to identify and document support and service needs, wants, and preferences.
- Negotiating payment rates for all paid community supports they want to purchase.
- Developing.and implementing employment/service agreements.

Families, with the help of their support broker, must develop a comprehensive support and spending plan based on the information gathered during the family-centered planning. The support and spending plan is reviewed and authorized by the Department and includes participant's preferences and interests by identifying all the supports and services, both paid and non-paid, and the participant's wants and needs to live successfully in their community.

Participants and their parentllegal guardian choose support services, categorized as "family-directed community supports," that will provide greater flexibility to meet the participant's needs in the following areas:

My Personal Needs - focuses on identifying supports and services needed to assure the person's health, safety, and basic quality oflife.

My Relationship Needs - identifies strategies in assisting an individual to establish and maintain relationships with immediate family members, friends, spouse, or other persons and build their natural support network.

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My Emotional Needs - addresses strategies in assisting an individual to learn and increasingly practice behaviors consistent with the person's identified goals and wishes while minimizing interfering behaviors.

My Learning Needs - identifies activities that support an individual in acquiring new skills or improving established skills that relate to a goal that the person has identified.

Participants and their parent/legal guardian choosing the Family-Directed Services option in Idaho are required to choose a qualified financial management services provider to provide Financial Management Services (FMS). The FMS provider is utilized to process and make payments to community support workers for the community support services contained in their support and spending plan. FMS providers have primary responsibility for monitoring the dollars spent in accordance with the itemized spending plan and for ensuring payment itemization and accuracy. Financial management service providers also manage payroll expenses including required tax withholding, unemployment/workers compensation insurance; ensuring completion of criminal history checks and providing monthly reports to the participant, parent/legal guardian and support broker if applicable. Financial Management service providers offer services on behalf of the participant in accordance with Section 3504 of the IRS code and the IRS Revenue Procedure 70-6, which outlines requirements of fmancial management service providers who are fiscal employer agents.

3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

X	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. *(Specify the areas of the State affected by this option):*

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
Community Support Services	X	X
Support Broker Services	X	X
Financial Management Services	X	X

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5. Financial Management. *(Select one):*

0	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
0	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.
X	Financial Services are furnished through a third party entity. *Specify whether governmental and/or private entities furnish these services.* 0 Governmental entities X Private entities

6. X Participant-Directed Plan of Care. *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the selvices to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for detennining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

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6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition/rom participant-direction, and specify any circumstances when transition is involuntary):*

The Department assists participants and the parent/legal guardian with this transition and assures that authorization for services under family-direction do not expire until new services are in place. The Department provides technical assistance and guidance as requested by participants and their parent/legal guardian, support brokers, and circles of support. Transition from family-direction to traditional services will not take more than 120 days and in most cases will be accomplished in 60 to 90 days. This transition time is spent re-determining the LOC needs, development of a new plan, and review and authorization of the new plan. The participant remains in family-direction until this process is completed so that there is no interruption in services. If at any time there are health and safety issues, the Department works closely with the participant and parent/legal guardian to ensure that the participant's health and safety is protected. This may include utilizing the Crisis Network Team to address any immediate crises and/or authorizing an emergency 120-day transition plan to assure a smooth transition from family-directed services to traditional services.

Only demonstrated danger to the participant's health and safety would result in the involuntary termination of the participant's use of family-direction. In these cases, the Departnlent will work closely with the parent/legal guardian and support broker to identify necessary changes to the plan of service, authorize emergency services if necessary, and facilitate any other activities necessary to assure continuity of services during this transition.

7. Opportunities for Participant-Direction

a. Participant-Employer Authority (individual can hire and supervise staff). *(Select one):*

○	The State does not offer opportunity for participant-employer authority.	
X	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide State plan HCBS. An agency is the common law employer of participant-selected/recruited staff and perfonns necessary payroll and human resources functions. SUPP0l1S are available to assist the participant in conducting employer-related functions.
	X	Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide State plan HCBS. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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b. Participant-Budget Authority (individual directs a budget). *(Select one):*

O	The State does not offer opportunity for participants to direct a budget.
X	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	The service and support desires and needs of participants measured by the Scales of Independent Behavior Revised (SIB-R), historical record of service expenditures when available, and the characteristics of persons served measured by the Idaho Individual Budget Screen are used in a stepwise regression analysis to develop a prospective individual budget for each participant. This budget-setting is completed in advance of the family-centered planning process and is used in the development of a family-centered plan. Participants and their parent/legal guardian using the family-directed pathway have the flexibility to choose providers and negotiate the rate of payment for their services. This flexibility allows them to make choices and prioritize needs in order to stay within an identified budget. Any participant has a right to an administrative hearing on decisions made by the Department concerning the family-directed support. Participant outcomes will be monitored using Quality Indicators and visitations from Department quality management staff. The individualized budget is based on the perspective that funding should be tied principally to individual need. The model seeks out the factors that contribute the most to explaining observed variance in costs and discards those that do not appear to influence cost. A review will be done on an annual basis to evaluate the current variables to determine if they continue to contribute to the cost of individuals. In the end, the model identifies the mix and weight of variables that best fits the array of observed costs across the individuals receiving services. This budget setting methodology process is reviewed with each participant and parent/legal guardian, during the initial and annual level of care assessment. It is documented publicly through the Administrative rulemaking process and published in the Idaho Administrative Code.
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

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	The participant and parent/legal guardian's selected Fiscal Employer Agent will have the individual budget and the approved supports and services from the support and spending plan. They will send monthly statements to participants and their parent/legal guardian on a monthly basis to infonn them on the status of expenditures. The support broker will assist the family to review these statements to assure. spending is on track, Employment agreements are developed for each community support worker that are descriptive to what is expected and how they will be paid.

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(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity *(Source of Data & ,ample size)*	Monitoring Responsibilities *(agency or entity that conducts discove1y activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes jor remediation)*	Frequency *ojAnalysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually,and document choice of services and providers.	1. Participants report satisfaction with their participation in activities within their communities.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Departtnent of Health and Welfare	Annually
	2. Service plans are revieWed md approved prior t0 the expiration of the participant's current plan of service.	100% of individual service plans (lSP) will be reviewed by the Department for prior authorization.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	3. Participants report their comments, questions and ideas were solicited and encouraged during the person-centered planning meeting.	Participant Experi Survey (PES) completed annually on arepresentatiye sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	4. Participants report they make choices abQUt their everyday life.	Compliance is based on weighted measure of series of PES questions. Annual PES will be completed for a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually

	5. Participants report they received support to learn something new in the past year.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	6. Participants report they know their plan developer/ monitor.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	7. Participants report their plan developer / monitor helps them get what they need.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	8. Requests to modify plans of service are reviewed and approved or denied within fifteen (15) days of their receipt.	Plan Authorization complete using representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	9. Claims indicate utilization consistent with the service type, scope, amount, duration and frequency approved on the participant's service plan.	System Data is reviewed for a representative sample with +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	10. Number and percent of service plans reviewed that addressed participant's functional needs as identified by the assessment.	100% of Service Plans are reviewed yearly by the Department and its contractor; and Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually

	11. Number and percent of participants report they were given a choice when selecting service provider(s).	Participant Experience Survey (PES) will be completed annually on a representative sample with a *+1- 5%* confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	12. Number and percent of participants reviewed who reported they have access to the services and supports they need.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	13. Number and percent of participants reviewed whose plan goal was achieved or modified in the past year.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
Providers meet required qualifications.	1. Number and percent of direct care staff meets state requirements for training.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	2. Number and percent of service providers, by provider type, who require licensure or certification have a current license or certificate at the time they provide Medicaid services to DD participants	System Data will be used to verify that 100% of service providers have current certification or licensure as required.	Department of Health and Welfare	Every 3 years	Department of Health and Welfare	Every 3 years
	3. Number and percent of non-licensed, non-certified service providers, by provider type, who demonstrate compliance with minimum provider requirements	System Data will be used to verify that 100% of service providers serving a representative sample of participants demonstrate compliance with minimum provider requirements.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually

The SMA retains authority and responsibility for program operations and oversight.	3. Number and percent of deficiencies corrected by the contractor as identified by the Department contract monitor	System Data is used to verify that 100% of all contractual obligations are addressed.	IAP Contractor	Ongoing and Quarterly	Department of Health and Welfare	Quarterly
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	1. Number and percent of demonstrated 1915i service providers fraudulent billing patterns investigated by DHW and action taken.	System Data is used to verify that 100% of the time appropriate investigation and follow up occurs when fraudulent billing is identified.	Department of Health and Welfare	Ongoing	Department of Health and Welfare	Ongoing and Annually
	2. Number and percent of invoices paid by Fiscal/Employer Agent in excess of the amount approved for identified support categories on each participants support and spending plan.	System Data will be used to demonstrate that 100% of the time appropriate Department investigation and follow up occurs when fraudulent billing is identified.	Department of Health and Welfare	Provider performance monitoring – Ongoing Financial Audits - Quarterly	Department of Health and Welfare	Ongoing, Quarterly and Annually
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. Number and percent of direct service providers who have signed a self declaration form and have not disclosed any designated crimes prior to working with participants.	System Data will demonstrate that 100% of service providers' providing direct services to participants in the representative sample have signed declaration forms.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	2. Number and percent of participants who reported that their service providers were reliable.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually

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	3. Number and percent of participants who reported that they are free from abuse, neglect and exploitation.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	4. Number of participants reviewed that reported they know the person/place to go to in order to report abuse.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	DeplU1ment of Health and Welfare	Annually	Department of Health and Welfare	Annually
	5. Number and percent of critical incidents that are investigated consistently with priority guidelines.	System data is used to verify the 100% of the time incidents are investigated consistently with guidelines.	Department of Health and Welfare	Ongoing	Department of Health and Welfare	Quarterly and Annually
	6. Number and percent of participants who reported support staff treated them with respect.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	7. Number and percent of participants who have had an annual medical evaluation.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	8. Number and percent of participants reviewed who have had a dental exam once every 6 months.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence Interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	9. Number and percent of critical incidents substantiated by type.	System data is used to verify the 100% of the time critical incidents are substantiated by type of incident.	Department of Health and Welfare	Ongoing	Department of Health and Welfare	Quarterly and Annually
	10. Number of substantiated complaints, by type.	System data is used to verify the 100% of the time complaints are substantiated by type of complaint.				

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System **Improvement:**

(Describe process for systems improvement as a result o a e Qted discover and remediation activities.

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles	Responsibilities	Frequency	Method for Evaluating Effectiveness of System Chan es
□ PES results are gathered; □ Regional complaints and incident reports are investigated □ Individual plans of service are reviewed by the Department	**Quality Management Staff**	This is a group of staff across seven regions of Idaho, with knowledge of quality improvement interventions, and who are responsible for collecting and reporting data to the Department.	Ongoing	Data is gatbered. and submitted to the Depal1inent's analyst.
□ Results of PES are reviewed and analyzed, and tabulated; □ Complaints and Critical Incidents are reviewed analyzed, and tabulated □ Plan of service information is analyzed	**Department Analyst**	This is department staff identified that lead statewide data collection activities, analysis, and reporting activities related to quality management. This staff is responsible for creating and implementing data collection tools.	Ongoing	The analyzed data is presented to the QA team for review and prioritization.
□ Quarterly meetings: Quarterly the committee reviews analyzed data to develop recommendations for program improvements, and reviews actions taken and progress made toward implementing previous approved system improvements. □ Annual meeting: Meets annually to prioritize findings and develop recommendations for specific system improvements for the coming year. This recommendation will be submitted to administration for approval and assignment.	**Quality Management Team**	The QM team is responsible for steering the quality assessment and improvement process, and issues related to parallel data collection. It is responsible for formally recommending specific program improvements to Department administration.	Quarterly	Annual QM report is submitted to administration.
□ Quarterly QM Report □ Annual QM Report	**Quality Management Manager**	The QM manager takes overall responsibility for leading team members, finalizing quarterly and yearly QM reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.	Quarterly and Yearly Report	Overall data findings and recommendations are submitted to the QM Team for review prior to finalization.

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1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

O	HCBS Case Management
O	HCBS Homemaker
O	HeBS Home Health Aide
O	HCBS Personal Care
☐	HCBS Adult Day Health
X	HCBS Habilitation Refer to attachment 4.19-B
X	HCBS Respite Care Refer to attacluIlent 4.19-B
For Individuals with Chronic Mental Illness, the following services:	
☐	HCSS Day Treatment or Other Partial Hospitalization Services
O	HCBS Psychosocial Rehabilitation
o	HCBS Clinic Services (whether or not furnished in a facility for eMI)
Other Services:	
X	Family Education Refer to attachment 4.19-B
Supports for Participant Direction:	
X	Community Support Services Refer to attachment 4.19-B
X	"Support Broker Refer to attacluIlent 4.19-B
X	Financial Management Services Refer to attachment 4.19-B

31. 1915(i) State Plan "CBS - Children with Developmental Disabilities

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

0	HCSS Case Management
0	HCSS Homemaker
0	HCSS Home Health Aide
0	HCSS Personal Care
0	HCSS Adult Day Health
X	HCSS Habilitation
	Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Habilitative Supports Individual and Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 31-1011) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .5% and SFY 2011 it is .8%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 85.5% of the target rate. We are using the most current *DD/MH* rates dictated by Idaho code 56-118 and used to calculate the 85.5% adjusted target rate.
X	HCSS Respite Care
	Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Respite Individual and Group, we use the Bureau of Labor statistics (BLS) mean wage (Idaho) for all others (BLS code 39-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using Global Insights Mountain States Market Basket (Gl) inflation index. In SFY 2010 (2 months) it was .5% and SFY 2011 it is .8%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the

	average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS Mountain West Division's (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate for Respite Individual is 77% of the target rate. The final unit rate for Respite group is 100% of the target rate. We are using the most current *DD/MH* rates dictated by Idaho code 56-118 and used to calculate the 77% and the 100% respectfully for the adjusted target rate.
For Individuals with Chronic Mental Illness, the following services:	
0	HCSS Day Treatment or Other Partial Hospitalization Services
0	HCSS Psychosocial Rehabilitation
0	HCSS Clinic Services (whether or not furnished in a facility for CMI)
Other Services:	
X	Family Education
	The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for Family Education Individual and Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 29-1129) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (01) index. In SFY 2010 (2 months) it was .5% and SFY 2011 it is .8%, Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWO) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 76.6% of the target rate. We are using the most current OO/MH rates dictated by Idaho code 56-118 and used to calculate the 76.6% adjusted target rate.
Supports for Participant Direction:	
X	Community Support Services
	The participant and parent/legal guardian negotiates the rate with community support staff, ensuring the rates negotiated do not exceed the prevailing market rate.

X	Support Broker
	The participant and parent/legal guardian negotiates the rate with the support broker, ensuring the negotiated rate does not exceed the maximum hourly rate for support broker services established by the Department.
X	Financial Management Services
	Financial Management Services -Reimbursement methodology for FMS is based on a market study of other state Medicaid program rates for FMS to gather a rang rate payn publ e schedule by th at le d when new pro publ request.